



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

PRESBYTERIAN HOSPITAL OF DALLAS  
3255 W PIONEER PARKWAY  
ARLINGTON TX 76013

DWC Claim #:  
Injured Employee:  
Date of Injury:  
Employer Name:  
Insurance Carrier #:

#### **Respondent Name**

ILLINOIS NATIONAL INSURANCE CO

#### **Carrier's Austin Representative Box**

Box Number 19

#### **MFDR Tracking Number**

M4-08-6927-01

#### **MFDR Date Received**

JULY 24, 2008

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "We have filed an MDR for this service because we believe that the reimbursement received for these services was not Fair and Reasonable. Few think that Medicare's reimbursement is Fair and Reasonable, as indicated by the Commission's implementation of 140% of Medicare rates for physicians and 213.3% of Medicare rate for free standing surgical centers. The Medicare MAR rate for this service is \$1109.81 times 140% is \$1553.75. We only received \$1118.00 in payment for this service. We request the insurance carrier pay the remaining balance of \$422.18."

**Amount in Dispute:** \$422.18

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** The insurance carrier, or its representative, did not submit a response to the request for medical fee dispute resolution.

### **SUMMARY OF FINDINGS**

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
October 16, 2007 October 18, 2007	Outpatient Hospital Services	\$422.18	\$0.00

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - 89 – Professional fees removed from charges. Radiology, lab, and/or pathology by a hosp, should normally

- be billed at the TC rate.
- W4 – No addl reimbursement allowed after review of appeal/reconsideration. Reimbursement for your no additional monies are being paid at this time. Bill has been paid according to state fee guidelines or rules and regulations.
- W10 – No maximum allowable defined by fee guideline. Reimbursement made based on insurance carrier fair and reasonable reimbursement methodology. Reduced to fair and reasonable.
- Paid in accordance with PPO contract: Corvel Corp P&T Standard.

## **Findings**

1. The insurance carrier reduced or denied disputed services with reason – “Paid in accordance with PPO contract: Corvel Corp P&T Standard.” The Division requested additional information on January 6, 2011 requesting a copy of the contract between the informal/voluntary network and Presbyterian Hospital of Dallas as described by Texas Labor Code §413.011(d01)(2) and documentation to support that Presbyterian Hospital of Dallas was notified in accordance with 28 Texas Administrative Code §133.4. The insurance carrier representative responded stating, “Corvel does not have a voluntary network contract. They only have a certified network [sic] contract. PPO [sic] contract was not used.” The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines
2. This dispute relates to services with reimbursement subject to the provisions of Texas Administrative Code §134.1, effective May 2, 2006, 31 *Texas Register* 3561, which requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers’ compensation health care network shall be made in accordance with subsection §134.1(d) which states that “Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available.”
3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual’s behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. 28 Texas Administrative Code §133.307(c)(2)(E), effective May 25, 2008, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, requires that the request shall include “a copy of all applicable medical records specific to the dates of service in dispute.” Review of the submitted documentation finds that the requestor has not provided copies of all medical records pertinent to the services in dispute. Although the requestor did submit a copy of the operative report, the requestor did not submit a copy of the anesthesia record, post-operative care record, or other pertinent medical records sufficient to support the services in dispute. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(E).
5. 28 Texas Administrative Code §133.307(c)(2)(G), effective May 25, 2008, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable.” Review of the submitted documentation finds that:
  - The requestor’s position statement for increased reimbursement from the *Table of Disputed Services* asserts that “the commission’s implementation of 140% of Medicare rates for physicians and 213.3% of Medicare rates for free standing surgical centers.”
  - The requestor does not discuss or explain how “the commission’s implementation of 140% of Medicare rates for physicians and 213.3% of Medicare rates for free standing surgical centers” supports the requestor’s position that the amount sought is a fair and reasonable reimbursement for the services in this dispute.
  - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
  - The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
  - The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

**Conclusion**

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services in dispute.

**Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

September 6, 2012  
\_\_\_\_\_  
Date

***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**